

# HEALTH & WELLBEING 2500 PLAN

FOR SMALL GROUP EMPLOYERS IN OREGON

## 2018 BENEFITS (Member pays)

The benefits information provided is a brief summary and not a complete description of benefits. Limitations and exclusions apply.

## HEALTH & WELLBEING 2500

WELLNESS SERVICES	In-network	Out-of-network
<b>Individual Wellness Assessment</b> Interactive, online questionnaire that evaluates lifestyle and its impact on good health.	\$0	Not covered
<b>Health Risk Screening</b> Blood test identifies risks for certain diseases and medical conditions.	\$0	Not covered
<b>Health Risk Score and Report</b> Provides a snapshot of the member's current health and recommends appropriate action items. Requires completion of Individual Wellness Assessment and Health Risk Screening test.	\$0	Not covered
<b>Personal Health Coaching</b> A trained, certified professional provides confidential, one-on-one sessions to assist members in reaching their health and wellness goals.	\$0	Not covered
MEDICAL BENEFITS		
<b>Deductible</b> Per calendar year Combined medical and pharmacy	\$2,500 per individual \$5,000 per family	\$5,000 per individual \$10,000 per family
<b>Out-of-pocket maximum</b> Per calendar year Combined medical and pharmacy	\$7,350 per individual \$14,700 per family	Unlimited
<b>Primary care <sup>1</sup></b> Office visits, in-office procedures	\$50, not subject to deductible	70%, after deductible
<b>Urgent care <sup>1</sup></b>	\$100, not subject to deductible	\$100, not subject to deductible
<b>Specialist visit <sup>1</sup></b> Office visits, in office procedures	\$100, not subject to deductible	70%, after deductible
<b>Emergency care</b> Waived if admitted to hospital	30%, after deductible	30%, after deductible
<b>Mental health and chemical dependency / substance abuse <sup>1</sup></b> Office visits	\$50, not subject to deductible	70%, after deductible
<b>Preventive care and services <sup>1</sup></b> Including well baby care, routine physicals, routine gynecological exams, immunizations, colorectal screening, ACA required services	\$0, not subject to deductible	70%, after deductible

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<b>Outpatient surgery (facility)</b> <sup>2</sup>	30%, after deductible	70%, after deductible
<b>Outpatient surgery (professional)</b> <sup>2</sup>	30%, after deductible	70%, after deductible
<b>Inpatient hospital</b> <sup>2</sup>	30%, after deductible	70%, after deductible
<b>Inpatient habilitative care</b> <sup>2</sup> 30 day limit*	30%, after deductible	70%, after deductible
<b>Inpatient rehabilitative care</b> <sup>2</sup> 30 day limit*	30%, after deductible	70%, after deductible
<b>Outpatient habilitative care</b> Occupational, physical, speech therapy; 30-60 combined visit limit per year depending on condition	\$100, after deductible	70%, after deductible
<b>Outpatient rehabilitative care</b> Occupational, physical, speech therapy; 30-60 combined visit limit per year depending on condition	\$100, after deductible	70%, after deductible
<b>Skilled nursing facility care</b> <sup>2</sup> 60 day limit*	30%, after deductible	70%, after deductible
<b>Radiology, labs</b> <sup>1,2</sup>	30%, not subject to deductible	70%, after deductible
<b>High tech imaging</b> <sup>2</sup> MRI, CT, PET, SPECT scans	30%, after deductible	70%, after deductible
<b>Mental health and chemical dependency / substance abuse</b> <sup>2</sup> Inpatient care and residential programs	30%, after deductible	70%, after deductible
<b>Injectable drugs</b> And other drugs administered other than orally (when rendered in the office)	30%, after deductible	70%, after deductible
<b>Ambulance, ground</b>	30%, after deductible	30%, after deductible
<b>Ambulance, air</b>	30%, after deductible	30%, after deductible
<b>Durable medical equipment (DME)</b> <sup>2</sup> Includes prosthetics, orthotics	30%, after deductible	70%, after deductible
<b>Home health care</b>	30%, after deductible	70%, after deductible
<b>Hospice</b> Respite care covered up to max 5 consecutive days, & 30 days lifetime	30%, after deductible	70%, after deductible
<b>Hearing aids / cochlear implants</b> 1 pair / 48 months for each impaired ear	30%, after deductible	70%, after deductible

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<b>Pediatric vision routine exam (ages 0-19)<sup>1</sup></b>	0%, not subject to deductible	70%, after deductible
<b>Pediatric vision hardware (ages 0-19)<sup>1</sup></b>	1 set of standard hardware (frames/lens) every year/contacts will have 40% coinsurance with no unit limit; not subject to deductible	70%, after deductible
<b>Transplants<sup>2</sup></b>	30%, after deductible	70%, after deductible
<b>Diabetes education<sup>1</sup></b>	\$50, not subject to deductible	70%, after deductible
<b>Nutritional counseling<sup>1</sup></b>	\$100, not subject to deductible	70%, after deductible
<b>Diabetic supplies<sup>1</sup></b>	\$0, not subject to deductible	70%, after deductible
<b>Alternative Care<sup>1</sup></b> \$1,000 combined limit for massage, chiropractic, acupuncture	\$25, not subject to deductible	70%, after deductible
PHARMACY BENEFITS		
<b>Tier 1: Preventive<sup>1</sup></b>	\$0, not subject to deductible	70%, not covered unless urgent or emergent, after deductible
<b>Tier 2: Generic<sup>1,2</sup></b>	\$20, not subject to deductible	70%, not covered unless urgent or emergent, after deductible
<b>Tier 3: Preferred<sup>1,2</sup></b>	\$60, not subject to deductible	70%, not covered unless urgent or emergent, after deductible
<b>Tier 4: Non-preferred<sup>2</sup></b>	50%, after deductible	70%, not covered unless urgent or emergent, after deductible
<b>Tier 5: High-cost specialty drugs<sup>2</sup></b>	50%, after deductible	70%, not covered unless urgent or emergent, after deductible

<sup>1</sup> Not subject to the deductible.

<sup>2</sup> May require Prior Authorization. See Prior Authorization list or Formulary for specific services or drugs that require authorization.

\* Limits do not apply to those services rendered for members with a Mental Health or Chemical Dependency/Substance Abuse diagnosis.

**In-network provider benefit**

Patient receives care from an in-network provider or facility, which has an effective provider Plan contract with Samaritan Health Plans to provide services and supplies to the covered individuals.

**Out-of-network provider benefit**

Patient receives care from a provider that has no affiliation or contractual arrangement with the Plan. At the out-of-network benefit level, payment to providers is based on the Samaritan Health Plans fee allowance or the billed amount, whichever is less. The fee allowance is often lower than, or discounted from, the physician's usual charge.

**Medical deductible and out-of-pocket maximums**

Please refer to the additional information provided in your Member Certificate for a further explanation of benefits including limitations and exclusions.

**Your deductible**

The deductible is the portion of covered benefit costs each member is obligated to pay before Samaritan Health Plans will provide benefits. The deductible amount for individuals and families is listed above. Your deductible is accumulated on a calendar year.

The following services, but not limited to, do not apply to your in-network provider deductible costs:

- Women's preventive services
- Men's preventive services
- Routine physical examinations
- Colorectal cancer screenings and exams
- Immunizations
- PKU test
- Well-baby/well-child care
- Outpatient diabetic instruction and supplies
- Preventive medications
- Generic medications
- Preferred brand medications
- Radiology
- Laboratory services
- Office and urgent care visits
- Pediatric vision
- Alternative care
- Wellness services

### **Your annual out-of-pocket limit**

You are responsible for the co-insurance or co-payment amount for each covered medical service listed under the Plan Benefits section of your Member Certificate until your medical out-of-pocket covered expenses reach your maximum out-of-pocket cost amount. The maximum out-of-pocket medical amount accumulates based on your own covered expenses every calendar year. This plan has in-network limits to protect you from excessive medical expenses. The summary above shows your plan's annual out-of-pocket limit. If you incur covered expenses over that amount, this plan will pay 100% of eligible charges for the rest of the calendar year for those services which are applicable to the out-of-pocket limit. Out-of-network services do NOT have an out-of-pocket limit.

Expenses for the following DO NOT count toward your out-of-pocket maximum limit:

- Charges over usual, customary, and reasonable amounts
- Benefits paid in full
- Incurred charges that exceed amounts allowed under this plan
- Non-medically necessary services, such as excluded services or those deemed to be not medically necessary by the plan
- Non-covered services, including those where a third party is responsible (COB, settlements, motor vehicle claims)

### **Prescription out-of-pocket maximum**

The Samaritan Health & Wellbeing 2500 has a combined pharmacy and medical out-of-pocket (OOP) maximum.

### **Member services department**

The Samaritan Health Plans home office in Corvallis is maintained to meet your servicing needs. Come see us at 2300 NW Walnut Boulevard or contact us at: 541-768-4550, toll free 1-800-832 4580 or TTY 1-800-735-2900. Our Member Services Department hours are 8 a.m. to 8 p.m., Monday through Friday. We look forward to serving you.

Statements made by applicants, policy holder or insured are representations and not warranties

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